110TH CONGRESS
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HOUSE OF REPRESENTATIVES
REPORT
110–680

HEALTH CENTERS RENEWAL ACT OF 2008

JUNE 4, 2008.—Committed to the Committee of the Whole House on the State of the Union and ordered to be printed

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Mr. DINGELL, from the Committee on Energy and Commerce, submitted the following

REPORT

[To accompany H.R. 1343]

[Including cost estimate of the Congressional Budget Office]

The Committee on Energy and Commerce, to whom was referred the bill (H.R. 1343) to amend the Public Health Service Act to provide additional authorizations of appropriations for the health centers program under section 330 of such Act, having considered the same, report favorably thereon with amendments and recommend that the bill as amended do pass.

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AMENDMENTS

The amendments are as follows:

Strike all after the enacting clause and insert the following:

SECTION 1. SHORT TITLE.

This Act may be cited as the "Health Centers Renewal Act of 2008".

SEC. 2. ADDITIONAL AUTHORIZATIONS OF APPROPRIATIONS FOR HEALTH CENTERS PROGRAM.

Section 330(r)(1) of the Public Health Service Act (42 U.S.C. 254b(r)(1)) is amended to read as follows:

"(1) IN GENERAL.—For the purpose of carrying out this section, in addition to the amounts authorized to be appropriated under subsection (d), there are authorized to be appropriated—

"(A) for fiscal year 2008, $2,213,020,000;
"(B) for fiscal year 2009, $2,451,394,400;
"(C) for fiscal year 2010, $2,757,818,700;
"(D) for fiscal year 2011, $3,116,335,131; and
"(E) for fiscal year 2012, $3,537,040,374.".

SEC. 3. RECOGNITION OF HIGH POVERTY AREAS.

(a) IN GENERAL.—Section 330(c) of the Public Health Service Act (42 U.S.C. 254b(c)) is amended by adding at the end the following new paragraph:

"(3) RECOGNITION OF HIGH POVERTY AREAS.—

"(A) IN GENERAL.—In making grants under this subsection, the Secretary may recognize the unique needs of high poverty areas.

"(B) HIGH POVERTY AREA DEFINED.—For purposes of subparagraph (A), the term 'high poverty area' means a catchment area which is established in a manner that is consistent with the factors in subsection (k)(3)(J), and the poverty rate of which is greater than the national average poverty rate as determined by the Bureau of the Census.".

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to grants made on or after January 1, 2009.

SEC. 4. LIABILITY PROTECTIONS FOR HEALTH CENTER VOLUNTEER PRACTITIONERS.

(a) IN GENERAL.—Section 224 of the Public Health Service Act (42 U.S.C. 233) is amended—

(1) in subsection (g)(1)(A)—

(A) in the first sentence, by striking "or employee" and inserting "employee, or (subject to subsection (k)(4)) volunteer practitioner"; and

(B) in the second sentence, by inserting "and subsection (k)(4)" after "subject to paragraph (5)"; and

(2) in each of subsections (g), (i), (j), (k), (l), and (m)—

(A) by striking the term "employee, or contractor" each place such term appears and inserting "employee, volunteer practitioner, or contractor";

(B) by striking the term "employee, and contractor" each place such term appears and inserting "employee, volunteer practitioner, and contractor";

(C) by striking the term "employee, or any contractor" each place such term appears and inserting "employee, volunteer practitioner, or contractor"; and

(D) by striking the term "employees, or contractors" each place such term appears and inserting "employees, volunteer practitioners, or contractors".

(b) APPLICABILITY; DEFINITION.—Section 224(k) of the Public Health Service Act (42 U.S.C. 233(k)) is amended by adding at the end the following paragraph:

"(4)(A) Subsections (g) through (m) apply with respect to volunteer practitioners beginning with the first fiscal year for which an appropriations Act provides that amounts in the fund under paragraph (2) are available with respect to such practitioners.

"(B) For purposes of subsections (g) through (m), the term 'volunteer practitioner' means a practitioner who, with respect to an entity described in subsection (g)(4), meets the following conditions:

"(i) In the State involved, the practitioner is a licensed physician, a licensed clinical psychologist, or other licensed or certified health care practitioner.

"(ii) At the request of such entity, the practitioner provides services to patients of the entity, at a site at which the entity operates or at a site designated by the entity. The weekly number of hours of services provided to the patients by the practitioner is not a factor with respect to meeting conditions under this subparagraph.

"(iii) The practitioner does not for the provision of such services receive any compensation from such patients, from the entity, or from third-party payors (including reimbursement under any insurance policy or health plan, or under any Federal or State health benefits program).".

SEC. 5. LIABILITY PROTECTIONS FOR HEALTH CENTER PRACTITIONERS PROVIDING SERVICES IN EMERGENCY AREAS.

Section 224(g) of the Public Health Service Act (42 U.S.C. 233(g)) is amended—

(1) in paragraph (1)(B)(ii), by striking "subparagraph (C)" and inserting "subparagraph (C) and paragraph (6)"; and

(2) by adding at the end the following paragraph:

"(6)(A) Subject to subparagraph (C), paragraph (1)(B)(ii) applies to health services provided to individuals who are not patients of the entity involved if, as determined under criteria issued by the Secretary, the following conditions are met:

"(i) The services are provided by a contractor, volunteer practitioner (as defined in subsection (k)(4)(B)), or employee of the entity who is a physician or other licensed or certified health care practitioner and who is otherwise deemed to be an employee for purposes of paragraph (1)(A) when providing services with respect to the entity.

"(ii) The services are provided in an emergency area (as defined in subparagraph (D)), with respect to a public health emergency or major disaster described in subparagraph (D), and during the period for which such emergency or disaster is determined or declared, respectively.

"(iii) The services of the contractor, volunteer practitioner, or employee (referred to in this paragraph as the 'out-of-area practitioner') are provided under an arrangement with—

"(I) an entity that is deemed to be an employee for purposes of paragraph (1)(A) and that serves the emergency area involved (referred to in this paragraph as an 'emergency-area entity'); or

"(II) a Federal agency that has responsibilities regarding the provision of health services in such area during the emergency.

"(iv) The purposes of the arrangement are—

"(I) to coordinate, to the extent practicable, the provision of health services in the emergency area by the out-of-area practitioner with the provision of services by the emergency-area entity, or by the Federal agency, as the case may be;

"(II) to identify a location in the emergency area to which such practitioner should report for purposes of providing health services, and to identify an individual or individuals in the area to whom the practitioner should report for such purposes; and

"(III) to verify the identity of the practitioner and that the practitioner is licensed or certified by one or more of the States.

"(v) With respect to the licensure or certification of health care practitioners, the provision of services by the out-of-area practitioner in the emergency area is not a violation of the law of the State in which the area is located.

"(B) In issuing criteria under subparagraph (A), the Secretary shall take into account the need to rapidly enter into arrangements under such subparagraph in order to provide health services in emergency areas promptly after the emergency begins.

"(C) Subparagraph (A) applies with respect to an act or omission of an out-of-area practitioner only to the extent that the practitioner is not immune from liability for such act or omission under the Volunteer Protection Act of 1997.

"(D) For purposes of this paragraph, the term 'emergency area' means a geographic area for which—

"(i) the Secretary has made a determination under section 319 that a public health emergency exists; or

"(ii) a presidential declaration of major disaster has been issued under section 401 of the Robert T. Stafford Disaster Relief and Emergency Assistance Act.".

SEC. 6. DEMONSTRATION PROJECT FOR INTEGRATED HEALTH SYSTEMS TO EXPAND ACCESS TO PRIMARY AND PREVENTIVE SERVICES FOR THE MEDICALLY UNDERSERVED.

Part D of title III of the Public Health Service Act (42 U.S.C. 259b et seq.) is amended by adding at the end the following new subpart:

"Subpart XI—Demonstration Project for Integrated Health Systems to Expand Access to Primary and Preventive Services for the Medically Underserved

"SEC. 340H. DEMONSTRATION PROJECT FOR INTEGRATED HEALTH SYSTEMS TO EXPAND ACCESS TO PRIMARY AND PREVENTIVE CARE FOR THE MEDICALLY UNDERSERVED.

"(a) ESTABLISHMENT OF DEMONSTRATION.—

"(1) IN GENERAL.—Not later than January 1, 2009, the Secretary shall establish a demonstration project (hereafter in this section referred to as the 'demonstration') under which up to 30 qualifying integrated health systems receive grants for the costs of their operations to expand access to primary and preventive services for the medically underserved.

"(2) RULE OF CONSTRUCTION.—Nothing in this section shall be construed as authorizing grants to be made or used for the costs of specialty care or hospital care furnished by an integrated health system.

"(b) APPLICATION.—Any integrated health system desiring to participate in the demonstration shall submit an application in such manner, at such time, and containing such information as the Secretary may require.

"(c) CRITERIA FOR SELECTION.—In selecting integrated health systems to participate in the demonstration (hereafter in this section referred to as 'participating integrated health systems'), the Secretary shall ensure representation of integrated health systems that are located in a variety of States (including the District of Columbia and the territories and possessions of the United States) and locations within States, including rural areas, inner-city areas, and frontier areas.

"(d) DURATION.—Subject to the availability of appropriations, the demonstration shall be conducted (and operating grants be made to each participating integrated health system) for a period of 3 years.

"(e) REPORTS.—

"(1) IN GENERAL.—The Secretary shall submit to the appropriate committees of the Congress interim and final reports with respect to the demonstration, with an interim report being submitted not later than 3 months after the demonstration has been in operation for 24 months and a final report being submitted not later than 3 months after the close of the demonstration.

"(2) CONTENT.—Such reports shall evaluate the effectiveness of the demonstration in providing greater access to primary and preventive care for medically underserved populations, and how the coordinated approach offered by integrated health systems contributes to improved patient outcomes.

"(f) AUTHORIZATION OF APPROPRIATIONS.—

"(1) IN GENERAL.—There is authorized to be appropriated $25,000,000 for each of the fiscal years 2009, 2010, and 2011 to carry out this section.

"(2) CONSTRUCTION.—Nothing in this section shall be construed as requiring or authorizing a reduction in the amounts appropriated for grants to health centers under section 330 for the fiscal years referred to in paragraph (1).

"(g) DEFINITIONS.—For purposes of this section:

"(1) FRONTIER AREA.—The term 'frontier area' has the meaning given to such term in regulations promulgated pursuant to section 330I(r).

"(2) INTEGRATED HEALTH SYSTEM.—The term 'integrated health system' means a health system that—

"(A) has a demonstrated capacity and commitment to provide a full range of primary care, specialty care, and hospital care in both inpatient and outpatient settings; and

"(B) is organized to provide such care in a coordinated fashion.

"(3) QUALIFYING INTEGRATED HEALTH SYSTEM.—

"(A) IN GENERAL.—The term 'qualifying integrated health system' means a public or private nonprofit entity that is an integrated health system that meets the requirements of subparagraph (B) and serves a medically underserved population (either through the staff and supporting resources of the integrated health system or through contracts or cooperative arrangements) by providing—

"(i) required primary and preventive health and related services (as defined in paragraph (4)); and

"(ii) as may be appropriate for a population served by a particular integrated health system, integrative health services (as defined in paragraph (5)) that are necessary for the adequate support of the required primary and preventive health and related services and that improve care coordination.

"(B) OTHER REQUIREMENTS.—The requirements of this subparagraph are that the integrated health system—

"(i) will make the required primary and preventive health and related services of the integrated health system available and accessible in the service area of the integrated health system promptly, as appropriate, and in a manner which assures continuity;

"(ii) will demonstrate financial responsibility by the use of such accounting procedures and other requirements as may be prescribed by the Secretary;

"(iii) provides or will provide services to individuals who are eligible for medical assistance under title XIX of the Social Security Act or for assistance under title XXI of such Act;

"(iv) has prepared a schedule of fees or payments for the provision of its services consistent with locally prevailing rates or charges and designed to cover its reasonable costs of operation and has prepared a corresponding schedule of discounts to be applied to the payment of such fees or payments, which discounts are adjusted on the basis of the patient's ability to pay;

"(v) will assure that no patient will be denied health care services due to an individual's inability to pay for such services;

"(vi) will assure that any fees or payments required by the system for such services will be reduced or waived to enable the system to fulfill the assurance described in clause (v);

"(vii) provides assurances that any grant funds will be expended to supplement, and not supplant, the expenditures of the integrated health system for primary and preventive health services for the medically underserved; and

"(viii) submits to the Secretary such reports as the Secretary may require to determine compliance with this subparagraph.

"(C) TREATMENT OF CERTAIN ENTITIES.—The term 'qualifying integrated health system' may include a nurse-managed health clinic if such clinic meets the requirements of subparagraphs (A) and (B) (except those requirements that have been waived under paragraph (4)(B)).

"(4) REQUIRED PRIMARY AND PREVENTIVE HEALTH AND RELATED SERVICES.—

"(A) IN GENERAL.—Except as provided in subparagraph (B), the term 'required primary and preventive health and related services' means basic health services consisting of—

"(i) health services related to family medicine, internal medicine, pediatrics, obstetrics, or gynecology that are furnished by physicians where appropriate, physician assistants, nurse practitioners, and nurse midwives;

"(ii) diagnostic laboratory services and radiologic services;

"(iii) preventive health services, including prenatal and perinatal care; appropriate cancer screening; well-child services; immunizations against vaccine-preventable diseases; screenings for elevated blood lead levels, communicable diseases, and cholesterol; pediatric eye, ear, and dental screenings to determine the need for vision and hearing correction and dental care; and voluntary family planning services;

"(iv) emergency medical services; and

"(v) pharmaceutical services, behavioral, mental health, and substance abuse services, preventive dental services, and recuperative care, as may be appropriate.

"(B) EXCEPTION.—In the case of an integrated health system serving a targeted population, the Secretary shall, upon a showing of good cause, waive the requirement that the integrated health system provide each required primary and preventive health and related service under this paragraph if the Secretary determines one or more such services are inappropriate or unnecessary for such population.

"(5) INTEGRATIVE HEALTH SERVICES.—The term 'integrative health services' means services that are not included as required primary and preventive health and related services and are associated with achieving the greater integration of a health care delivery system to improve patient care coordination so that the system either directly provides or ensures the provision of a broad range of culturally competent services. Integrative health services include but are not limited to the following:

"(A) Outreach activities.

"(B) Case management and patient navigation services.

"(C) Chronic care management.

"(D) Transportation to health care facilities.

"(E) Development of provider networks and other innovative models to engage local physicians and other providers to serve the medically underserved within a community.

"(F) Recruitment, training, and compensation of necessary personnel.

"(G) Acquisition of technology for the purpose of coordinating care.

"(H) Improvements to provider communication, including implementation of shared information systems or shared clinical systems.

"(I) Determination of eligibility for Federal, State, and local programs that provide, or financially support the provision of, medical, social, housing, educational, or other related services.

"(J) Development of prevention and disease management tools and processes.

"(K) Translation services.

"(L) Development and implementation of evaluation measures and processes to assess patient outcomes.

"(M) Integration of primary care and mental health services.

"(N) Carrying out other activities that may be appropriate to a community and that would increase access by the uninsured to health care, such as access initiatives for which private entities provide non-Federal contributions to supplement the Federal funds provided through the grants for the initiatives.

"(6) SPECIALTY CARE.—The term 'specialty care' means care that is provided through a referral and by a physician or nonphysician practitioner, such as surgical consultative services, radiology services requiring the immediate presence of a physician, audiology, optometric services, cardiology services, magnetic resonance imagery (MRI) services, computerized axial tomography (CAT) scans, nuclear medicine studies, and ambulatory surgical services.

"(7) NURSE-MANAGED HEALTH CLINIC.—The term 'nurse-managed health clinic' means a nurse-practice arrangement, managed by advanced practice nurses, that provides care for underserved and vulnerable populations and is associated with a school, college, or department of nursing or an independent nonprofit health or social services agency.".

Amend the title so as to read:

A bill to amend the Public Health Service Act to provide additional authorizations of appropriations for the health centers program under section 330 of such Act, and for other purposes.

PURPOSE AND SUMMARY

The purpose of H.R. 1343, the Health Centers Renewal Act of 2008, is to reauthorize community health centers for fiscal years 2008 through 2012, authorize the Secretary to acknowledge the unique needs of high-poverty areas for planning grants, grant liability protection for practitioners who volunteer at the centers or travel to provide services in emergencies, and authorize a demonstration project for integrated health systems to expand access to primary and preventive care for the medically underserved.

BACKGROUND AND NEED FOR LEGISLATION

For more than 40 years, community health centers have provided comprehensive, culturally competent, quality primary healthcare services—including preventive, diagnostic, treatment, emergency services, and referrals to specialty care—to medically underserved communities and vulnerable populations without access to such services. Where medically necessary, community health centers also provide enabling services, such as transportation and translation that help patients gain access to care. Patients are charged for services based on their ability to pay, on a sliding-fee scale.

Reauthorization of the Health Centers Program. H.R. 1343 reauthorizes community health centers for fiscal years 2008 through

2012, under section 330 of the Public Health Service (PHS) Act, as amended (42 U.S.C. 254b).

The Committee clarifies the authority of the Secretary, pursuant to subsection (e)(1)(B), to waive all or part of the statutory requirements set forth in subsection (k), including the governance requirement. Therefore, the Secretary may make grants, for a period not to exceed two years, for the costs of the operation of public and nonprofit private entities that provide health services to medically underserved populations, but with respect to which the Secretary is unable to make each of the determinations required by subsection (k)(3).

The Committee notes that the determination made by the Committee with respect to the waiver authority of the Secretary is shared by the U.S. Department of Health and Human Services and is reflected in a letter addressed to the Committee dated April 22, 2008. The letter is provided here in its entirety.

DEPARTMENT OF HEALTH & HUMAN SERVICES, HEALTH RESOURCES AND SERVICES ADMINISTRATION, BUREAU OF PRIMARY HEALTH CARE,

Rockville, MD, April 22, 2008.

Hon. FRANK PALLONE,
Chairman, Health Subcommittee, Energy and Commerce Committee,
House of Representatives, Washington, DC.

DEAR CHAIRMAN PALLONE, This letter is in response to your request for information regarding the Health Resources and Services Administration's (HRSA) authority to waive the statutory governance requirements for health centers. Section 330(e)(1)(B) of the Public Health Service Act permits HRSA to issue a waiver of the statutory requirements under subsection (k)(3) for up to 2 years. Additionally, under Section 330(e)(4), this waiver may be extended for another 2 years, for a total waiver period of up to 4 years.

Section 330(e) grantees may therefore be relieved of certain requirements including, but not limited to, the provisions related to the composition and authorities of the governing board under subsection (k)(3)(H). The statute gives the Secretary discretion as to whether he opts to grant such waivers.

Thank you for your efforts to reauthorize the Health Center Program. I am sending the same letter to Congressman Nathan Deal.

Sincerely,

JAMES MACRAE,
Associate Administrator.

Furthermore, the Committee observes that "look-alike" centers, as outlined in the Social Security Act, must meet the same standards as Federally Qualified Health Centers (FQHCs) receiving grants under Section 330 of the PHS Act. The Committee clarifies that the waiver authority of the Secretary under subsection (e)(1)(B) is also available to the Secretary when making the determination that an entity applying for look-alike status meets the requirements set forth under Section 330. This observation does not expand the scope of the Secretary's waiver authority under existing law, but rather clarifies the current waiver authority of the Secretary.

Recognition of High-Poverty Areas. Planning grants are considered useful aids to the development of viable proposals to establish new health center sites that will meet Federal requirements for governance, community involvement, quality of care, and financial feasibility under the Health Center Program. H.R. 1343 would grant the Secretary authority to recognize the unique needs of high-poverty areas when making grants under subsection (c).

The Committee encourages the Secretary to use this authority to improve the geographic diversity and placement of new planning grants in the poorest areas with the highest capacity to support a comprehensive health center. The Committee encourages new grantees in high-poverty areas, including, but not limited to, pockets of high-poverty and medically underserved areas in otherwise affluent counties.

Liability Protection for Health Center Volunteer Practitioner. Health practitioners may otherwise be willing to volunteer their services at a community health center, but may refrain from volunteering because of the fear of malpractice liability or the increasing cost of medical malpractice insurance. H.R. 1343 would amend section 224 of the PHS Act (42 U.S.C. 233) to extend Federal medical malpractice protection to qualified healthcare practitioners who volunteer at community health centers within the scope of its approved Federal project. Currently, healthcare practitioners who volunteer at community health centers are not eligible for Federal Tort Claims Act (FTCA) coverage.

Where a volunteer healthcare practitioner meets all the requirements under section 224, he or she may be sponsored by a community health center and "deemed" a Federal employee for the purpose of FTCA medical malpractice coverage. When making the determination to deem volunteer practitioners under this authority, the Secretary is encouraged to ensure such determination is consistent with the scope of the approved Federal project of the sponsoring community health center.

Liability Protection for Health Center Practitioners Providing Services in Emergency Areas. In an effort to build upon the Federally Supported Health Centers Assistance Act of 1992 (Public Law 102–501), H.R. 1343 would clarify that certain physicians or other licensed or certified healthcare practitioners have Federal liability protection for the purposes of any civil action that may arise due to services provided in an emergency area. Such services must be provided under an arrangement with a qualified health center or with a Federal agency with responsibility for providing health services in the emergency area.

FTCA protection is also extended to qualified volunteer practitioners for services provided in an emergency area, as long as they are permitted to volunteer under State and Federal laws. The intent is to increase the numbers of qualified health care practitioners who are available to community health centers to work as part of the organized State or local response to natural disasters or man-made emergencies.

Demonstration Project for Integrated Health Systems to Expand Access to Primary and Preventative Services for the Medically Underserved. H.R. 1343 would establish a demonstration project for qualifying integrated health systems to expand access to primary and preventive care for the medically underserved. The Committee

strongly encourages the Secretary to select participants that represent a diverse assortment of rural, frontier, and urban communities, drawn from various locations within the States and/or a region/group of States. This representation is necessary to ensure that the demonstration project explores the capacity of (wide ranging needs of the) integrated health systems to expand access to primary and preventive care and improve patient outcomes in a variety of medically underserved communities.

Hearings

On Tuesday, December 4, 2007, the Subcommittee on Health held a hearing on H.R. 1343 and two other bills. The hearing included testimony from Dennis P. Williams, Ph.D., Deputy Administrator, Health Resources and Services Administration; Mr. Wilbert Jones, Chief Executive Officer, Greater Meridian Health Clinic; Stephen Miracle, M.B.A., Executive Director, Georgia Mountain Health Services, Inc.; Ricardo Guzman, M.S.W., M.P.H., Chief Executive Officer, Community Health and Social Services, Inc.; and Michael Ehlert, M.D., President, American Student Medical Association.

Committee Consideration

On Wednesday, April 23, 2008, the Subcommittee on Health met in open markup session and favorably forwarded H.R. 1343, amended, to the full Committee for consideration by a voice vote. On Wednesday, May 7, 2008, the full Committee met in open markup session and ordered H.R. 1343 favorably reported to the House, amended, by a voice vote.

Committee Votes

Clause 3(b) of rule XIII of the Rules of the House of Representatives requires the Committee to list the record votes on the motion to report legislation and amendments thereto. No record votes were taken on amendments or in connection with ordering H.R. 1343 reported to the House. A motion by Mr. Dingell to order H.R. 1343 favorably reported to the House, amended, was agreed to by a voice vote.

Committee Oversight Findings

Regarding clause 3(c)(1) of rule XIII of the Rules of the House of Representatives, the Subcommittee on Health held a legislative hearing on H.R. 1343, and the oversight findings of the Committee regarding the bill are reflected in this report.

Statement of General Performance Goals and Objectives

The purpose of H.R. 1343 is to expand access to primary and preventive care by ensuring that community health centers can continue to offer health care services to millions of medically underserved and uninsured people.

New Budget Authority, Entitlement Authority, and Tax Expenditures

Regarding compliance with clause 3(c)(2) of rule XIII of the Rules of the House of Representatives, the Committee finds that H.R. 1343 would result in no new or increased budget authority, entitlement authority, or tax expenditures or revenues.

Earmarks and Tax and Tariff Benefits

Regarding compliance with clause 9 of rule XXI of the Rules of the House of Representatives, H.R. 1343 does not contain any Congressional earmarks, limited tax benefits, or limited tariff benefits as defined in clause 9(d), 9(e), or 9(f) of rule XXI.

Committee Cost Estimate

The Committee adopts as its own the cost estimate on H.R. 1343 prepared by the Director of the Congressional Budget Office pursuant to section 402 of the Congressional Budget Act of 1974.

Congressional Budget Office Estimate

Pursuant to clause 3(c)(3) of rule XIII of the Rules of the House of Representatives, the following is the cost estimate on H.R. 1343 provided by the Congressional Budget Office pursuant to section 402 of the Congressional Budget Act of 1974:

June 3, 2008.

Hon. John D. Dingell,
Chairman, Committee on Energy and Commerce,
House of Representatives, Washington, DC.

Dear Mr. Chairman: The Congressional Budget Office has prepared the enclosed cost estimate for H.R. 1343, the Health Centers Renewal Act of 2008.

If you wish further details on this estimate, we will be pleased to provide them. The CBO staff contact is Lara Robillard.

Sincerely,

Peter R. Orszag.

Enclosure.

H.R. 1343—Health Centers Renewal Act of 2008

Summary: H.R. 1343 would amend the Public Health Service Act to authorize a program that provides funding for community health centers. It would also expand the pool of individuals covered by the Federal Tort Claims Act (FTCA) and authorize a three-year demonstration project for integrated health systems.

CBO estimates that the bill would authorize the appropriation for those activities of $2.2 billion for 2008 and $14.2 billion over the 2008–2013 period. However, $2.0 billion has already been appropriated for 2008 for health centers. Thus, H.R. 1343 would authorize the appropriation of an additional $0.2 billion for fiscal year 2008 and $12.1 billion over the 2008–2013 period. Assuming the appropriation of authorized amounts, CBO estimates that the bill would cost $77 million in 2008 and $11.8 billion over the 2008–2013 period.

Enacting H.R. 1343 would not affect direct spending or revenues. H.R. 1343 contains no intergovernmental or private-sector mandates as defined in the Unfunded Mandates Reform Act (UMRA) and would impose no costs on state, local, or tribal governments.

Estimated cost to the Federal Government: The estimated budgetary impact of H.R. 1343 is shown in the following table. The costs of this legislation fall within budget function 550 (health).

	By fiscal year, in millions of dollars—						
	2008	2009	2010	2011	2012	2013	2008–2013
CHANGES IN SPENDING SUBJECT TO APPROPRIATION							
Health Centers:							
Authorization Level	191	2,451	2,758	3,116	3,537	0	12,053
Estimated Outlays	77	1,397	2,505	2,883	3,266	1,579	11,707
FTCA Expansion:							
Estimated Authorization Level	0	2	2	2	2	2	10
Estimated Outlays	0	0	1	1	2	2	6
Integrated Health System Demonstration:							
Authorization Level	0	25	25	25	0	0	75
Estimated Outlays	0	5	20	25	20	5	75
Total:							
Estimated Authorization Level	191	2,478	2,785	3,143	3,539	2	12,138
Estimated Outlays	77	1,402	2,526	2,909	3,288	1,586	11,788

Basis of estimate: H.R. 1343 would authorize the health centers program, which funds community-based and patient-directed organizations that serve populations with limited access to primary health care services. In total, CBO estimates that the bill would authorize the appropriation of $2.2 billion for 2008 and $14.1 billion over the 2008–2013 period. The Omnibus Appropriations Act (Public Law 110–161) appropriated $2.2 billion in 2008 for health centers. Thus, H.R. 1343 would authorize the appropriation of an additional $191 million for fiscal year 2008 and $12.1 billion over the 2008–2013 period for health centers.

Assuming the appropriation of the additional funds for 2008 in the early summer, and the appropriation of the authorized amounts in subsequent years, CBO estimates that spending for the community health center program from the funds that would be authorized by this bill would total $77 million in 2008 and $11.7 billion over the 2008–2013 period.

Under current law, liability protections under the Federal Tort Claims Act (FTCA) are granted to employees and contractors of participating health centers, because those individuals are considered employees of the federal government. Therefore, the government defends all medical liability claims against health center employees and pays any claims arising from liability. H.R. 1343 would grant that protection to health care professionals who volunteer at health centers.

Under H.R. 1343, the liability protection for volunteers would be conditional upon the appropriation of funds, in addition to existing FTCA resources, for the purposes of covering volunteers.[1] CBO assumes that funds would be appropriated beginning in fiscal year 2009 and each year thereafter. Based on historical program expenditures for existing liability protections and the potential role of

[1] The Omnibus Appropriations Act of 2007 appropriated $43 million for FTCA coverage of health center employees.

volunteer staff at health centers, CBO estimates that covering volunteers under the FTCA would require the appropriation of $2 million for 2009 and $ 10 million over the 2010–2013 period. CBO estimates that implementing the FTCA expansion would cost less than $500,000 in 2009 and $6 million over the 2009–2013 period, assuming appropriation of the necessary amounts.

H.R. 1343 also would extend liability protection to health center practitioners who provide services in emergency areas. Under current law, FTCA liability protection applies when health center practitioners treat patients of the health center where they work, except in limited circumstances. H.R. 1343 would broaden the application of the FTCA so that health center practitioners would be covered when treating people at a health center in an area that has been declared a public health emergency or major disaster area. Because this provision would not add new practitioners to the FTCA coverage, but rather would allow practitioners to carry the liability protection with them to new sites, CBO expects that this expansion of coverage under the FTCA would not have a significant budgetary impact.

H.R. 1343 would authorize a grant program to allow integrated health systems to expand access to primary and preventive care for the medically underserved. The legislation defines eligible integrated health systems as public or non-profit entities that serve a medically underserved population and deliver specific primary and preventive care services. The legislation would authorize the appropriation of $25 million a year for fiscal years 2009 through 2011. Based on information provided by the Health Resources and Services Administration, CBO estimates that implementing the grant program would cost $5 million in 2009 and $75 million over the 2009–2013 period, assuming the appropriation of authorized amounts.

Intergovernmental and private-sector impact: H.R. 1343 contains no intergovernmental or private-sector mandates as defined in UMRA. Funds authorized in the bill would benefit local governments that participate in community health programs.

Previous CBO estimate: On March 20, CBO released a cost estimate for S. 901, the Health Care Safety Net Act of 2007. Like H.R. 1343, S. 901 would authorize funding for health centers; however, S. 901 does not include the liability protection and demonstration provisions included in H.R. 1343. In addition, S. 901 would authorize funding for two other HRSA programs: the National Health Service Corps and Rural Health Outreach Grants.

Estimate prepared by: Federal Costs: Lara Robillard; Impact on State, Local, and Tribal Governments: Lisa Ramirez-Branum; Impact on the Private Sector: Keisuke Nakagawa.

Estimate approved by: Keith J. Fontenot, Deputy Assistant Director for Health and Human Resources, Budget Analysis Division.

Federal Mandates Statement

The Committee adopts as its own the estimate of Federal mandates regarding H.R. 1343 prepared by the Director of the Congressional Budget Office pursuant to section 423 of the Unfunded Mandates Reform Act.

Advisory Committee Statement

No advisory committees within the meaning of section 5(b) of the Federal Advisory Committee Act would be created by H.R. 1343.

Constitutional Authority Statement

Pursuant to clause 3(d)(1) of rule XIII of the Rules of the House of Representatives, the Committee finds that the Constitutional authority for H.R. 1343 is provided in Article I, section 8, clause 3, which grants Congress the power to regulate commerce with foreign nations, among the several States, and with the Indian Tribes, and in the provisions of Article I, section 8, clause 1, that relate to expending funds to provide for the general welfare of the United States.

Applicability to Legislative Branch

The Committee finds that H.R. 1343 does not relate to the terms and conditions of employment or access to public services or accommodations within the meaning of section 102(b)(3) of the Congressional Accountability Act of 1995.

Section-by-Section Analysis of the Legislation

Section 1. Short title

Section 1 specifies the short title of the legislation as the "Health Centers Renewal Act of 2008."

Section 2. Additional authorizations of appropriations for health centers programs

Section 2 sets forth the authorizations of appropriations for fiscal years 2008 through 2012.

Section 3. Recognition of high-poverty areas

Section 3 authorizes the Secretary to acknowledge the unique needs of high-poverty areas for planning grants.

Section 4. Liability protections for health center volunteer practitioners

Section 4 grants liability protection for practitioners who volunteer at the centers. This provision would apply in the first fiscal year for which an appropriations Act made such funds available.

Section 5. Liability protections for health center practitioners providing services in emergency areas

Section 5 grants liability protection for practitioners who, under an arrangement with a qualified health center or with a Federal agency with responsibility for providing health services in the emergency area, travel to provide services in emergencies to individuals who are not patients of the community health center involved.

Section 6. Recognition of high-poverty areas

Section 6 authorizes a demonstration project for integrated health systems to expand access to primary and preventive care for the medically underserved.

CHANGES IN EXISTING LAW MADE BY THE BILL, AS REPORTED

In compliance with clause 3(e) of rule XIII of the Rules of the House of Representatives, changes in existing law made by the bill, as reported, are shown as follows (existing law proposed to be omitted is enclosed in black brackets, new matter is printed in italics, existing law in which no change is proposed is shown in roman):

PUBLIC HEALTH SERVICE ACT

* * * * * * *

TITLE II—ADMINISTRATION AND MISCELLANEOUS PROVISIONS

PART A—ADMINISTRATION

* * * * * * *

DEFENSE OF CERTAIN MALPRACTICE AND NEGLIGENCE SUITS

SEC. 224. (a) * * *

* * * * * * *

(g)(1)(A) For purposes of this section and subject to the approval by the Secretary of an application under subparagraph (D), an entity described in paragraph (4), and any officer, governing board member, [or employee] *employee, or (subject to subsection (k)(4)) volunteer practitioner* of such an entity, and any contractor of such an entity who is a physician or other licensed or certified health care practitioner (subject to paragraph (5)), shall be deemed to be an employee of the Public Health Service for a calendar year that begins during a fiscal year for which a transfer was made under subsection (k)(3) (subject to paragraph (3)). The remedy against the United States for an entity described in paragraph (4) and any officer, governing board member, [employee, or contractor] *employee, volunteer practitioner, or contractor* (subject to paragraph (5) *and subsection (k)(4)*) of such an entity who is deemed to be an employee of the Public Health Service pursuant to this paragraph shall be exclusive of any other civil action or proceeding to the same extent as the remedy against the United States is exclusive pursuant to subsection (a).

(B) The deeming of any entity or officer, governing board member, [employee, or contractor] *employee, volunteer practitioner, or contractor* of the entity to be an employee of the Public Health Service for purposes of this section shall apply with respect to services provided—

(i) to all patients of the entity, and

(ii) subject to subparagraph (C) *and paragraph (6)*, to individuals who are not patients of the entity.

(C) Subparagraph (B)(ii) applies to services provided to individuals who are not patients of an entity if the Secretary determines, after reviewing an application submitted under subparagraph (D), that the provision of the services to such individuals—

(i) * * *

* * * * * * *

(iii) are otherwise required under an employment contract (or similar arrangement) between the entity and an officer, governing board member, [employee, or contractor] *employee, volunteer practitioner, or contractor* of the entity.

(D) The Secretary may not under subparagraph (A) deem an entity or an officer, governing board member, [employee, or contractor] *employee, volunteer practitioner, or contractor* of the entity to be an employee of the Public Health Service for purposes of this section, and may not apply such deeming to services described in subparagraph (B)(ii), unless the entity has submitted an application for such deeming to the Secretary in such form and such manner as the Secretary shall prescribe. The application shall contain detailed information, along with supporting documentation, to verify that the entity, and the officer, governing board member, [employee, or contractor] *employee, volunteer practitioner, or contractor* of the entity, as the case may be, meets the requirements of subparagraphs (B) and (C) of this paragraph and that the entity meets the requirements of paragraphs (1) through (4) of subsection (h).

(E) The Secretary shall make a determination of whether an entity or an officer, governing board member, [employee, or contractor] *employee, volunteer practitioner, or contractor* of the entity is deemed to be an employee of the Public Health Service for purposes of this section within 30 days after the receipt of an application under subparagraph (D). The determination of the Secretary that an entity or an officer, governing board member, [employee, or contractor] *employee, volunteer practitioner, or contractor* of the entity is deemed to be an employee of the Public Health Service for purposes of this section shall apply for the period specified by the Secretary under subparagraph (A).

(F) Once the Secretary makes a determination that an entity or an officer, governing board member, [employee, or contractor] *employee, volunteer practitioner, or contractor* of an entity is deemed to be an employee of the Public Health Service for purposes of this section, the determination shall be final and binding upon the Secretary and the Attorney General and other parties to any civil action or proceeding. Except as provided in subsection (i), the Secretary and the Attorney General may not determine that the provision of services which are the subject of such a determination are not covered under this section.

* * * * * * *

(H) In the case of an entity described in paragraph (4) for which an application under subparagraph (D) is in effect, the entity may, through notifying the Secretary in writing, elect to terminate the applicability of this subsection to the entity. With respect to such election by the entity:

(i) * * *

(ii) Upon taking effect, the election terminates the applicability of this subsection to the entity and each officer, governing board member, [employee, and contractor] *employee, volunteer practitioner, and contractor* of the entity.

* * * * * * *

(iv) If after making the election the entity submits an application under subparagraph (D), the election does not preclude

the Secretary from approving the application (and thereby restoring the applicability of this subsection to the entity and each officer, governing board member, [employee, and contractor] *employee, volunteer practitioner, and contractor* of the entity, subject to the provisions of this subsection and the subsequent provisions of this section.

* * * * * * *

(6)(A) Subject to subparagraph (C), paragraph (1)(B)(ii) applies to health services provided to individuals who are not patients of the entity involved if, as determined under criteria issued by the Secretary, the following conditions are met:

(i) The services are provided by a contractor, volunteer practitioner (as defined in subsection (k)(4)(B)), or employee of the entity who is a physician or other licensed or certified health care practitioner and who is otherwise deemed to be an employee for purposes of paragraph (1)(A) when providing services with respect to the entity.

(ii) The services are provided in an emergency area (as defined in subparagraph (D)), with respect to a public health emergency or major disaster described in subparagraph (D), and during the period for which such emergency or disaster is determined or declared, respectively.

(iii) The services of the contractor, volunteer practitioner, or employee (referred to in this paragraph as the "out-of-area practitioner") are provided under an arrangement with—

(I) an entity that is deemed to be an employee for purposes of paragraph (1)(A) and that serves the emergency area involved (referred to in this paragraph as an "emergency-area entity"); or

(II) a Federal agency that has responsibilities regarding the provision of health services in such area during the emergency.

(iv) The purposes of the arrangement are—

(I) to coordinate, to the extent practicable, the provision of health services in the emergency area by the out-of-area practitioner with the provision of services by the emergency-area entity, or by the Federal agency, as the case may be;

(II) to identify a location in the emergency area to which such practitioner should report for purposes of providing health services, and to identify an individual or individuals in the area to whom the practitioner should report for such purposes; and

(III) to verify the identity of the practitioner and that the practitioner is licensed or certified by one or more of the States.

(v) With respect to the licensure or certification of health care practitioners, the provision of services by the out-of-area practitioner in the emergency area is not a violation of the law of the State in which the area is located.

(B) In issuing criteria under subparagraph (A), the Secretary shall take into account the need to rapidly enter into arrangements under such subparagraph in order to provide health services in emergency areas promptly after the emergency begins.

(C) Subparagraph (A) applies with respect to an act or omission of an out-of-area practitioner only to the extent that the practitioner

is not immune from liability for such act or omission under the Volunteer Protection Act of 1997.

(D) For purposes of this paragraph, the term "emergency area" means a geographic area for which—

(i) the Secretary has made a determination under section 319 that a public health emergency exists; or

(ii) a presidential declaration of major disaster has been issued under section 401 of the Robert T. Stafford Disaster Relief and Emergency Assistance Act.

(h) The Secretary may not approve an application under subsection (g)(1)(D) unless the Secretary determines that the entity—

(1) * * *

* * * * * * *

(3) has no history of claims having been filed against the United States as a result of the application of this section to the entity or its officers, [employees, or contractors] *employees, volunteer practitioners, or contractors* as provided for under this section, or, if such a history exists, has fully cooperated with the Attorney General in defending against any such claims and either has taken, or will take, any necessary corrective steps to assure against such claims in the future; and

(4) will fully cooperate with the Attorney General in providing information relating to an estimate described under subsection (k).

(i)(1) Notwithstanding subsection (g)(1), the Attorney General, in consultation with the Secretary, may on the record determine, after notice and opportunity for a full and fair hearing, that an individual physician or other licensed or certified health care practitioner who is an officer, [employee, or contractor] *employee, volunteer practitioner, or contractor* of an entity described in subsection (g)(4) shall not be deemed to be an employee of the Public Health Service for purposes of this section, if treating such individual as such an employee would expose the Government to an unreasonably high degree of risk of loss because such individual—

(A) * * *

* * * * * * *

(j) In the case of a health care provider who is an officer, [employee, or contractor] *employee, volunteer practitioner, or contractor* of an entity described in subsection (g)(4), section 335(e) shall apply with respect to the provider to the same extent and in the same manner as such section applies to any member of the National Health Service Corps.

(k)(1)(A) For each fiscal year, the Attorney General, in consultation with the Secretary, shall estimate by the beginning of the year the amount of all claims which are expected to arise under this section (together with related fees and expenses of witnesses) for which payment is expected to be made in accordance with section 1346 and chapter 171 of title 28, United States Code, from the acts or omissions, during the calendar year that begins during that fiscal year, of entities described in subsection (g)(4) and of officers, [employees, or contractors] *employees, volunteer practitioners, or contractors* (subject to subsection (g)(5)) of such entities.

(B) The estimate under subparagraph (A) shall take into account—

(i) the value and frequency of all claims for damage for personal injury, including death, resulting from the performance of medical, surgical, dental, or related functions by entities described in subsection (g)(4) or by officers, [employees, or contractors] *employees, volunteer practitioners, or contractors* (subject to subsection (g)(5)) of such entities who are deemed to be employees of the Public Health Service under subsection (g)(1) that, during the preceding 5-year period, are filed under this section or, with respect to years occurring before this subsection takes effect, are filed against persons other than the United States,

* * * * * * *

(3) In order for payments to be made for judgments against the United States (together with related fees and expenses of witnesses) pursuant to this section arising from the acts or omissions of entities described in subsection (g)(4) and of officers, [employees, or contractors] *employees, volunteer practitioners, or contractors* (subject to subsection (g)(5)) of such entities, the total amount contained within the fund established by the Secretary under paragraph (2) for a fiscal year shall be transferred not later than the December 31 that occurs during the fiscal year to the appropriate accounts in the Treasury.

(4)(A) Subsections (g) through (m) apply with respect to volunteer practitioners beginning with the first fiscal year for which an appropriations Act provides that amounts in the fund under paragraph (2) are available with respect to such practitioners.

(B) For purposes of subsections (g) through (m), the term "volunteer practitioner" means a practitioner who, with respect to an entity described in subsection (g)(4), meets the following conditions:

(i) In the State involved, the practitioner is a licensed physician, a licensed clinical psychologist, or other licensed or certified health care practitioner.

(ii) At the request of such entity, the practitioner provides services to patients of the entity, at a site at which the entity operates or at a site designated by the entity. The weekly number of hours of services provided to the patients by the practitioner is not a factor with respect to meeting conditions under this subparagraph.

(iii) The practitioner does not for the provision of such services receive any compensation from such patients, from the entity, or from third-party payors (including reimbursement under any insurance policy or health plan, or under any Federal or State health benefits program).

(l)(1) If a civil action or proceeding is filed in a State court against any entity described in subsection (g)(4) or any officer, governing board member, [employee, or any contractor] *employee, volunteer practitioner, or contractor* of such an entity for damages described in subsection (a), the Attorney General, within 15 days after being notified of such filing, shall make an appearance in such court and advise such court as to whether the Secretary has determined under subsections (g) and (h), that such entity, officer, governing board member, [employee, or contractor] *employee, volunteer practitioner, or contractor* of the entity is deemed to be an employee of the Public Health Service for purposes of this section with respect to the actions or omissions that are the subject of such

civil action or proceeding. Such advice shall be deemed to satisfy the provisions of subsection (c) that the Attorney General certify that an entity, officer, governing board member, [employee, or contractor] *employee, volunteer practitioner, or contractor* of the entity was acting within the scope of their employment or responsibility.

(2) If the Attorney General fails to appear in State court within the time period prescribed under paragraph (1), upon petition of any entity or officer, governing board member, [employee, or contractor] *employee, volunteer practitioner, or contractor* of the entity named, the civil action or proceeding shall be removed to the appropriate United States district court. The civil action or proceeding shall be stayed in such court until such court conducts a hearing, and makes a determination, as to the appropriate forum or procedure for the assertion of the claim for damages described in subsection (a) and issues an order consistent with such determination.

(m)(1) An entity or officer, governing board member, [employee, or contractor] *employee, volunteer practitioner, or contractor* of an entity described in subsection (g)(1) shall, for purposes of this section, be deemed to be an employee of the Public Health Service with respect to services provided to individuals who are enrollees of a managed care plan if the entity contracts with such managed care plan for the provision of services.

(2) Each managed care plan which enters into a contract with an entity described in subsection (g)(4) shall deem the entity and any officer, governing board member, [employee, or contractor] *employee, volunteer practitioner, or contractor* of the entity as meeting whatever malpractice coverage requirements such plan may require of contracting providers for a calendar year if such entity or officer, governing board member, [employee, or contractor] *employee, volunteer practitioner, or contractor* of the entity has been deemed to be an employee of the Public Health Service for purposes of this section for such calendar year. Any plan which is found by the Secretary on the record, after notice and an opportunity for a full and fair hearing, to have violated this subsection shall upon such finding cease, for a period to be determined by the Secretary, to receive and to be eligible to receive any Federal funds under titles XVIII or XIX of the Social Security Act.

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TITLE III—GENERAL POWERS AND DUTIES OF PUBLIC HEALTH SERVICE

* * * * * * *

PART D—PRIMARY HEALTH CARE

Subpart I—Health Centers

SEC. 330. HEALTH CENTERS.

(a) * * *

* * * * * * *

(c) PLANNING GRANTS.—

(1) * * *

* * * * * * *

(3) RECOGNITION OF HIGH POVERTY AREAS.—

(A) IN GENERAL.—In making grants under this subsection, the Secretary may recognize the unique needs of high poverty areas.

(B) HIGH POVERTY AREA DEFINED.—For purposes of subparagraph (A), the term "high poverty area" means a catchment area which is established in a manner that is consistent with the factors in subsection (k)(3)(J), and the poverty rate of which is greater than the national average poverty rate as determined by the Bureau of the Census.

* * * * * * *

(r) AUTHORIZATION OF APPROPRIATIONS.—

[(1) IN GENERAL.—For the purpose of carrying out this section, in addition to the amounts authorized to be appropriated under subsection (d), there are authorized to be appropriated $1,340,000,000 for fiscal year 2002 and such sums as may be necessary for each of the fiscal years 2003 through 2006.]

(1) IN GENERAL.—For the purpose of carrying out this section, in addition to the amounts authorized to be appropriated under subsection (d), there are authorized to be appropriated—

(A) for fiscal year 2008, $2,213,020,000;

(B) for fiscal year 2009, $2,451,394,400;

(C) for fiscal year 2010, $2,757,818,700;

(D) for fiscal year 2011, $3,116,335,131; and

(E) for fiscal year 2012, $3,537,040,374.

* * * * * * *

Subpart XI—Demonstration Project for Integrated Health Systems to Expand Access to Primary and Preventive Services for the Medically Underserved

SEC. 340H. DEMONSTRATION PROJECT FOR INTEGRATED HEALTH SYSTEMS TO EXPAND ACCESS TO PRIMARY AND PREVENTIVE CARE FOR THE MEDICALLY UNDERSERVED.

(a) ESTABLISHMENT OF DEMONSTRATION.—

(1) IN GENERAL.—Not later than January 1, 2009, the Secretary shall establish a demonstration project (hereafter in this section referred to as the "demonstration") under which up to 30 qualifying integrated health systems receive grants for the costs of their operations to expand access to primary and preventive services for the medically underserved.

(2) RULE OF CONSTRUCTION.—Nothing in this section shall be construed as authorizing grants to be made or used for the costs of specialty care or hospital care furnished by an integrated health system.

(b) APPLICATION.—Any integrated health system desiring to participate in the demonstration shall submit an application in such manner, at such time, and containing such information as the Secretary may require.

(c) CRITERIA FOR SELECTION.—In selecting integrated health systems to participate in the demonstration (hereafter in this section referred to as "participating integrated health systems"), the Secretary

shall ensure representation of integrated health systems that are located in a variety of States (including the District of Columbia and the territories and possessions of the United States) and locations within States, including rural areas, inner-city areas, and frontier areas.

(d) DURATION.—Subject to the availability of appropriations, the demonstration shall be conducted (and operating grants be made to each participating integrated health system) for a period of 3 years.

(e) REPORTS.—

(1) IN GENERAL.—The Secretary shall submit to the appropriate committees of the Congress interim and final reports with respect to the demonstration, with an interim report being submitted not later than 3 months after the demonstration has been in operation for 24 months and a final report being submitted not later than 3 months after the close of the demonstration.

(2) CONTENT.—Such reports shall evaluate the effectiveness of the demonstration in providing greater access to primary and preventive care for medically underserved populations, and how the coordinated approach offered by integrated health systems contributes to improved patient outcomes.

(f) AUTHORIZATION OF APPROPRIATIONS.—

(1) IN GENERAL.—There is authorized to be appropriated $25,000,000 for each of the fiscal years 2009, 2010, and 2011 to carry out this section.

(2) CONSTRUCTION.—Nothing in this section shall be construed as requiring or authorizing a reduction in the amounts appropriated for grants to health centers under section 330 for the fiscal years referred to in paragraph (1).

(g) DEFINITIONS.—For purposes of this section:

(1) FRONTIER AREA.—The term "frontier area" has the meaning given to such term in regulations promulgated pursuant to section 330I(r).

(2) INTEGRATED HEALTH SYSTEM.—The term "integrated health system" means a health system that—

(A) has a demonstrated capacity and commitment to provide a full range of primary care, specialty care, and hospital care in both inpatient and outpatient settings; and

(B) is organized to provide such care in a coordinated fashion.

(3) QUALIFYING INTEGRATED HEALTH SYSTEM.—

(A) IN GENERAL.—The term "qualifying integrated health system" means a public or private nonprofit entity that is an integrated health system that meets the requirements of subparagraph (B) and serves a medically underserved population (either through the staff and supporting resources of the integrated health system or through contracts or cooperative arrangements) by providing—

(i) required primary and preventive health and related services (as defined in paragraph (4)); and

(ii) as may be appropriate for a population served by a particular integrated health system, integrative health services (as defined in paragraph (5)) that are necessary for the adequate support of the required pri-

mary and preventive health and related services and that improve care coordination.

(B) OTHER REQUIREMENTS.—The requirements of this subparagraph are that the integrated health system—

(i) will make the required primary and preventive health and related services of the integrated health system available and accessible in the service area of the integrated health system promptly, as appropriate, and in a manner which assures continuity;

(ii) will demonstrate financial responsibility by the use of such accounting procedures and other requirements as may be prescribed by the Secretary;

(iii) provides or will provide services to individuals who are eligible for medical assistance under title XIX of the Social Security Act or for assistance under title XXI of such Act;

(iv) has prepared a schedule of fees or payments for the provision of its services consistent with locally prevailing rates or charges and designed to cover its reasonable costs of operation and has prepared a corresponding schedule of discounts to be applied to the payment of such fees or payments, which discounts are adjusted on the basis of the patient's ability to pay;

(v) will assure that no patient will be denied health care services due to an individual's inability to pay for such services;

(vi) will assure that any fees or payments required by the system for such services will be reduced or waived to enable the system to fulfill the assurance described in clause (v);

(vii) provides assurances that any grant funds will be expended to supplement, and not supplant, the expenditures of the integrated health system for primary and preventive health services for the medically underserved; and

(viii) submits to the Secretary such reports as the Secretary may require to determine compliance with this subparagraph.

(C) TREATMENT OF CERTAIN ENTITIES.—The term "qualifying integrated health system" may include a nurse-managed health clinic if such clinic meets the requirements of subparagraphs (A) and (B) (except those requirements that have been waived under paragraph (4)(B)).h (4)(B)).

(4) REQUIRED PRIMARY AND PREVENTIVE HEALTH AND RELATED SERVICES.—

(A) IN GENERAL.—Except as provided in subparagraph (B), the term "required primary and preventive health and related services" means basic health services consisting of—

(i) health services related to family medicine, internal medicine, pediatrics, obstetrics, or gynecology that are furnished by physicians where appropriate, physician assistants, nurse practitioners, and nurse midwives;

(ii) diagnostic laboratory services and radiologic services;

(iii) preventive health services, including prenatal and perinatal care; appropriate cancer screening; well-child services; immunizations against vaccine-preventable diseases; screenings for elevated blood lead levels, communicable diseases, and cholesterol; pediatric eye, ear, and dental screenings to determine the need for vision and hearing correction and dental care; and voluntary family planning services;

(iv) emergency medical services; and

(v) pharmaceutical services, behavioral, mental health, and substance abuse services, preventive dental services, and recuperative care, as may be appropriate.

(B) EXCEPTION.—In the case of an integrated health system serving a targeted population, the Secretary shall, upon a showing of good cause, waive the requirement that the integrated health system provide each required primary and preventive health and related service under this paragraph if the Secretary determines one or more such services are inappropriate or unnecessary for such population.

(5) INTEGRATIVE HEALTH SERVICES.—The term "integrative health services" means services that are not included as required primary and preventive health and related services and are associated with achieving the greater integration of a health care delivery system to improve patient care coordination so that the system either directly provides or ensures the provision of a broad range of culturally competent services. Integrative health services include but are not limited to the following:

(A) Outreach activities.

(B) Case management and patient navigation services.

(C) Chronic care management.

(D) Transportation to health care facilities.

(E) Development of provider networks and other innovative models to engage local physicians and other providers to serve the medically underserved within a community.

(F) Recruitment, training, and compensation of necessary personnel.

(G) Acquisition of technology for the purpose of coordinating care.

(H) Improvements to provider communication, including implementation of shared information systems or shared clinical systems.

(I) Determination of eligibility for Federal, State, and local programs that provide, or financially support the provision of, medical, social, housing, educational, or other related services.

(J) Development of prevention and disease management tools and processes.

(K) Translation services.

(L) Development and implementation of evaluation measures and processes to assess patient outcomes.

(M) Integration of primary care and mental health services.

(N) Carrying out other activities that may be appropriate to a community and that would increase access by the uninsured to health care, such as access initiatives for which

private entities provide non-Federal contributions to supplement the Federal funds provided through the grants for the initiatives.

(6) SPECIALTY CARE.—The term "specialty care" means care that is provided through a referral and by a physician or nonphysician practitioner, such as surgical consultative services, radiology services requiring the immediate presence of a physician, audiology, optometric services, cardiology services, magnetic resonance imagery (MRI) services, computerized axial tomography (CAT) scans, nuclear medicine studies, and ambulatory surgical services.

(7) NURSE-MANAGED HEALTH CLINIC.—The term "nurse-managed health clinic" means a nurse-practice arrangement, managed by advanced practice nurses, that provides care for underserved and vulnerable populations and is associated with a school, college, or department of nursing or an independent nonprofit health or social services agency.

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